12 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Daily tooth brushing ☐ First dental appointment White spots on teeth ☐ yes ☐ no

NUTRITIONAL SCREEN:: [X] INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula:_____
☐ Adequate intake Solids: _____
☐ Supplements_____ ☐ Soda ☐ Juice

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ First steps ☐ "Mama" "dada" specific ☐ Uses single words ☐ Scribbles ☐ Precise pincer grasp ☐ Follows simple one step requests ☐ Looks for hidden objects ☐ Extends arm/leg for dressing ☐ Point to/label pictures ☐ Plays: hides object/pushes ball back and forth ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Passive smoke ☐ Car seat safety/20#'s AND 1 year = forward facing ☐ Weaning plan/milk intake ☐ Discipline/praise ☐ Follow child's lead in play ☐ Ignore tantrums/give attention to positive behaviors ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ Prefers primary care giver over all others ☐ Shy/anxious with strangers

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine (scoliosis)		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP:

LABS ORDERED:	[X] INDICATES ORDERED ☐ Blood Lead Test **(perform at 12 months)** ☐.TB skin test **(if at risk)** ☐Other
IMMUNIZATIONS:	[X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ Hep A ☐ HepB ☐ MMR ☐ Varicella ☐ DtaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza
REFERRALS:	[X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/ DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Dental ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

Revised November 1, 2007